B. Determine the operating costs for day outliers for each admission in item A that is recognized in outlier payments. For each base year admission that is a day outlier, cut the operating cost of that admission at the trim point by multiplying the operating cost of that admission by the ratio of the admission's days of inpatient hospital services in excess of the trim point, divided by the admission's length of stay, and then multiply the cut operating cost by each hospital's elected outlier percentage or 70 percent if an election is not made. When neonate or burn diagnostic categories are used, the department shall substitute 90 percent for the 70 percent or elected percentage.

C. For each admission, subtract item B from item A, and for each hospital, add the results within each program and rehabilitation distinct part specialty group, and divide this amount by the number of admissions within each program and the rehabilitation distinct part specialty group.

D. Adjust item C for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of admissions by program and the rehabilitation distinct part specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital admissions and round that quotient to five decimal places.

(4) Divide the cost per admission as determined in item C by the quotient calculated in subitem (3) and round that amount to whole dollars.

5.02 Adjusted base year operating cost per day outlier for Minnesota and local trade area hospitals. The Department determines the adjusted base year operating cost per day outlier by program and the rehabilitation distinct part specialty group for each hospital according to items A and B.

A. To determine the allowable operating cost per day that is recognized in outlier payments, add the amounts calculated in Section 5.01, item B and divide the total by the total number of days of inpatient hospital services in excess of the trim point.

B. Adjust item A for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of outlier days by program and the rehabilitation distinct part specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add the products determined in subitem (1).
(3) Divide the total from subitem (2) by the number of hospital outlier days.

(4) Divide the cost per day outlier as determined in item A by the quotient calculated in subitem (3) and round that amount to whole dollars.

5.03 Out-of-area hospitals. The Department determines the adjusted base year operating cost per admission and per day outlier by program ~~and specialty group~~ according to items A to C.

A. Multiply each adjusted base year operating cost per admission and per day outlier ~~in effect on the first day of a rate year~~ for each Minnesota and local trade area hospital determined in Sections 5.01 and 5.02 by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all the hospitals and round that amount to whole dollars.

5.04 Minnesota MSA and local trade area hospitals that do not have five or more Medical Assistance admissions or five or more day ~~outliers~~ outlier Medical Assistance admissions in the base year and ~~MSA~~ low volume local trade area hospitals ~~located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota~~. The Department determines the adjusted base year operating cost per admission or per day outlier by program ~~and specialty group~~ according to items A to C.

A. Multiply each adjusted base year cost per admission and per day outlier ~~in effect on the first day of a rate year~~ for each Minnesota MSA and local trade area hospital determined in Sections 5.01 and 5.02 by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all Minnesota MSA and local trade area hospitals and round that amount to whole dollars.

5.05 Non-MSA hospitals that do not have five or more Medical Assistance admissions or five or more day ~~outliers~~ outlier Medical Assistance admissions in the base year. The Department determines the adjusted base year operating cost per admission or per day outlier by program ~~and specialty group~~ for non-MSA hospitals by substituting non-MSA hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 5.04.

5.06 Minnesota and local trade area hospitals that do not have five or more Medical Assistance (including General Assistance Medical Care, a State-funded program) rehabilitation distinct part specialty group admissions or five or more day outlier Medical Assistance rehabilitation distinct part specialty group admissions in the base year. The Department determines the adjusted base year operating cost per admission or per day outlier for the rehabilitation distinct part specialty group for Minnesota and local trade area hospitals by substituting Minnesota and local trade area hospital terms and data for the metropolitan statistical area hospital terms and data under Section 5.04.

5.07 Non-seven-county metropolitan area hospitals. The Department determines the non-seven-county metropolitan area hospital adjusted base year operating cost per admission or per day outlier, by program and specialty group under Section 15.10, by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 5.04.

~~5.07~~ 5.08 Limitation on separate payment. Out-of-area hospitals that have a rate established under Section 5.03 may not have certified registered nurse anesthetists services paid separately from this Attachment.

SECTION 6.0 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER DAY

6.01 Neonatal transfers For Minnesota and local trade area hospitals, the Department determines the neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a neonatal intensive care unit (NICU) speciality group according to items A to F.

A. Determine the operating cost per day within each diagnostic category as defined at Section 2.0, item D, according to Section 4.01, items A to E, and divide the total base year operating costs by the total corresponding inpatient hospital days for each admission.

B. Determine relative values for each diagnostic category at Section 2.0, item D, according to Section 4.01, items F,

G, and H, after substituting the term "day" for "admission."

C. For each Minnesota and local trade area hospital that has admissions that result from a transfer to a neonatal intensive care unit speciality group, determine the operating cost for each admission according to Section 4.01, items A to E.

D. Add the results for each admission in subitem C.

E. Divide the total from item D by the total corresponding inpatient hospital days for each admission in item C.

F. Adjust item E for case mix according to Section 5.01, subitem D, after substituting the term "day" for "admission."

6.02 Minnesota ~~MSA~~ and local trade area hospitals that do not have five or more Medical Assistance neonatal transfer admissions in the base year. The Department determines the neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a NICU speciality group according to items A to C.

A. Multiply each adjusted base year operating cost per day ~~in effect on the first day of a rate year~~ for each Minnesota ~~MSA~~ and local trade area hospital determined in Section 6.01, item F, by the number of corresponding days in the hospital's base year.

B. Add the products in ~~subitem (1)~~ item A.

C. Divide the total from ~~subitem (2)~~ item B by the total days for all Minnesota ~~MSA~~ and local trade area hospitals and round that amount to whole dollars.

~~**6.03 Non-MSA hospitals that do not have Medical Assistance neonatal transfer admissions in the base year.** The Department determines the adjusted base year operating cost per day for admissions that result from a transfer to a NICU by substituting non-MSA hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 6.02.~~

~~6.04~~ **Non-seven-county metropolitan area hospitals.** The Department determines the non-seven-county metropolitan area hospital neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a NICU under Section 15.10 by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 6.02.

~~6.05~~ 6.04 **Long-term care hospital.**

The Department determines the base year operating cost per day for ~~hospital admissions to~~ long-term care hospitals for the rate year according to items A and B.

A. Determine the operating cost per day according to Section 4.01, items A to D, except that claims excluded in Section 4.01, item B, subitems (2) and (4), will be included.

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B. Divide the total base year operating costs for all admissions in item A by the total corresponding inpatient hospital days for all admissions and round that amount to whole dollars.

~~6.06~~ 6.05 Long-term care hospitals that do not have five or more Medical Assistance (including General Assistance Medical Care, a State-funded program) admissions in the base year. The Department determines the operating cost per day according to items A to C.

A. Multiply each operating cost per day ~~in effect on the first day of a rate year for each long-term care hospital~~ for each long-term care hospital as determined in Section 6.04, item B, by the number of corresponding days in that hospital's base year.

B. Add the products in item A.

C. Divide the total of item B by the total days for all long-term care hospitals and round that amount to whole dollars.

SECTION 7.0 DETERMINATION OF HOSPITAL COST INDEX (HCI)

7.01 Adoption of HCI. The most recent *Health Care Costs* published by Data Resources Incorporated (DRI) is used.

7.02 Determination of HCI. For the period from the midpoint of each hospital's base year to the midpoint of the rate year, or, when the base year is not rebased, from the midpoint of the prior rate year to the midpoint of the current rate year, the Department determines the HCI according to items A to C.

A. For each rate year, the Department obtains from DRI the average annual historical and projected cost change estimates in a decimal format for the operating costs by applying the change in the Consumer Price Index - All Items (United States city average) (CPI-U) in the third quarter of the prior rate year.

B. Add one to the amounts in item A and multiply these amounts together. Round the result to three decimal places.

C. For the 2002 rate year, the HCI is zero.

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SECTION 8.0 DETERMINATION OF PROPERTY COST PER ADMISSION

8.01 Minnesota and local trade area hospitals. The Department determines the property cost per admission for each Minnesota and local trade area hospital according to items A to D.

A. Determine the property cost for each admission in Section 4.01, item C, using each hospital's base year data according to subitems (1) to (4).

(1) Multiply the number of accommodation service inpatient days by that accommodation service property per diem and add the products.

(2) Multiply each ancillary charge by that ancillary property cost-to-charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the results of subitem (3) for all admissions for each hospital.

B. Determine the property cost for each hospital admission in Section 4.01, item C, using each hospital's base year data and recent year Medicare cost report data that was submitted by the October 1 prior to a rebased rate year according to subitems (1) to (4).

(1) Multiply the base year number of accommodation service inpatient days by that same recent year accommodation service property per diem and add the products.

(2) Multiply each base year ancillary charge by that annualized recent year property cost to base year charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the totals of subitem (3) for all admissions for each hospital.

C. Determine the change in the property cost according to subitems (1) to (3).

(1) Subtract item A, subitem (4) from item B, subitem (4), and, if positive, divide the result by item A, subitem (4).

(2) Multiply the quotient of subitem (1) by 0.85.

(3) Add one to the result of subitem (2) and round to two decimal places.

D. Determine the property cost per admission by program and specialty group according to subitems (1) to (3).

(1) Assign each admission and property cost in item A, subitem (3) to the appropriate diagnostic category program and specialty group.

(2) Multiply the cost of each admission in subitem (1) by the factor in item C, subitem (3).

(3) Add the products within each program and specialty group in subitem (2), divide the total by the number of corresponding admissions, and round the resulting amount to whole dollars.

8.02 Out-of-area hospitals. The Department determines the property cost per admission by program according to items A to C.

A. Multiply each property cost per admission ~~in effect on the first day of a rate year~~ for each Minnesota and local trade

area hospital determined in Section 8.01, item D, subitem (3), by the number of corresponding admissions in that hospital's base year.

B. Add the products in item A.

C. Divide the total from B by the total admissions for all the hospitals and round the resulting amount to whole dollars.

8.03 Minnesota MSA and local trade area hospitals that do not have five or more Medical Assistance admissions in the base year and ~~MSA~~ low volume local trade area hospitals ~~located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota~~. The Department determines the property cost per admission by program ~~and specialty group~~ according to items A to C.

A. Multiply each property cost per admission ~~in effect on the first day of a rate year~~ for each Minnesota MSA and local trade area ~~MSA~~ hospital determined in Section 8.01, item D, subitem (3), by the number of corresponding admissions in the hospital's base year.

B. Add the products in item A.

C. Divide the total of item B by the total admissions for all Minnesota MSA hospitals and local trade area hospitals and round the resulting amount to whole dollars.

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8.04 Non-MSA hospitals that do not have five or more Medical Assistance admissions in the base year. The Department determines the property cost per admission by program ~~and specialty group by substituting~~ for non-MSA hospitals that do not have five or more Medical Assistance admissions in the base year by substituting non-MSA area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 8.03.

8.05 Minnesota and local trade area hospitals that do not have five or more Medical Assistance (including General Assistance Medical Care, a State-funded program) rehabilitation distinct part specialty group admissions in the base year. The Department determines the property cost per admission for the rehabilitation distinct part specialty group for Minnesota and local trade area hospitals that do not have five or more Medical Assistance admissions in the base year substituting Minnesota and local trade area hospital terms and data for the Minnesota MSA and local trade area hospital terms and data under Section 8.03.

8.06 Non-seven county metropolitan area hospitals. The Department determines the non-seven-county metropolitan area hospital property cost per admission by program and specialty group under Section 15.10 by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 8.03.

SECTION 9.0 DETERMINATION OF PROPERTY COST PER DAY

9.01 Neonatal transfers.

A. For Minnesota and local trade area hospitals, the Department will determine the property cost per day for neonatal transfer admissions that result from a transfer to a NICU specialty group according to Section 8.01, item D, after substituting the term "day" for "admission."

B. For Minnesota and local trade area hospitals that do not have five or more Medical Assistance neonatal transfer admissions in the base year, the Department ~~will determine~~ determines the neonatal transfer property cost per day for admissions in the base year according to Section 8.03 after substituting the term "day" for "admission."

C. For non-seven-county metropolitan area hospitals, the Department will determine the non-seven-county metropolitan area hospital neonatal transfer property cost per day for neonatal transfer admissions in the base year under Section 15.10 by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data according to Section 8.03, after substituting the term "day" for "admission."

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A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient rate.

B. Add 1.0 to the amount in item A.

C. If the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in Section 13.01, item C, the payment adjustment determined in item A is multiplied by 1.1 and added to 1.0.

D. Payment adjustments under this section are reduced by the amount of any payment received under Sections 13.01 to 13.04.

Payments made under this section are not disproportionate share hospital payment adjustments under §1923 of the Social Security Act.

15.05 Rebasing adjustment. Payment to Minnesota and local trade area hospitals for admissions excluding Medicare crossovers, occurring on or after October 25, 1993 include a rebasing adjustment that is designed to prospectively compensate for an effective date of July 1, 1992 under the rates and rules in effect on October 25, 1993.

For a case mix appeal filed after July 1, 1997, the combined difference in case mix for Medical Assistance and General Assistance Medical Care, a State-funded program, must exceed five percent. For this paragraph, "hospital" means a facility holding the provider number as an inpatient service facility.

C. To appeal a payment rate or payment change that results from Medicare adjustments of base year information, the 60-day appeal period begins on the mailing date of the notice by the Medicare program or the date the Medical Assistance payment rate determination notice is mailed, whichever is later.

D. As part of the appeals process, hospitals are allowed to seek changes that result from differences in the type of services provided or patient acuity from the base year. This is necessary because of the time lag between the base year and the rate year. These case mix appeals are calculated after the rate year has finished. However, in a few situations such as the creation of a new program, it is prospectively evident that a case mix appeal will be successful. Therefore, in these cases, an agreement is drafted mandating a case mix appeal calculation at the end of the year and estimated payments are made on an interim basis.

SECTION 15.0 OTHER PAYMENT FACTORS

15.01 Charge limitation. Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

15.02 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

15.03 Small rural payment adjustment.

A. Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds on March 1, 1988, and 100 or fewer Minnesota Medical Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 20 percent.
B. Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds and greater than 100 but fewer than 250 Minnesota Medical Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 15 percent.

The payment adjustment does not include Medicare crossover admissions in the admissions count nor are Medicare crossover admissions eligible for the percentage increase. Minnesota hospitals located in a city of the first class are not eligible for the payment adjustment in this section. Minnesota hospitals that receive the non-seven-county metropolitan area hospital payment adjustment under Section 15.10 are also not eligible for the payment adjustment in Section 15.03.

The small rural payment adjustment is reduced by the amount of the hospital's DPA under Sections 13.01 to 13.05 and the hospital payment adjustment under Section 15.04.

15.04 Hospital payment adjustment. If federal financial participation is not available for all payments made under Sections 13.01 to 13.04 and payments are made under Section 13.05 or if a hospital does not meet the criteria of Section 13.01, items A or B, and the Medical Assistance inpatient utilization rate exceeds the mean in Section 13.01, item C, a payment adjustment is determined as follows:

13.06 Additional DPA. A DPA will be paid to eligible hospitals in addition to any other DPA payment as calculated under Sections 13.01 to 13.04. A hospital is eligible for this additional payment if it had:

A. Medical Assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total Medical Assistance fee-for-service payment volume. Hospitals meeting this criteria will be paid $1,515,000 each month beginning July 15, 1995.

B. A hospital is eligible for this additional payment if it had Medical Assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total Medical Assistance fee-for-service payment volume and is affiliated with the University of Minnesota. A hospital meeting this criteria will be paid $505,000 each month beginning July 15, 1995.

SECTION 14.0 APPEALS

A hospital may appeal a decision arising from the application of standards or methods of the payment system. An appeal can result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that are discovered as a result of the submission of appeals will be implemented. Regardless of any appeal outcome, relative values shall not be recalculated.

The appeal will be heard by an administrative law judge according to Minnesota Statutes, chapter 14, or upon agreement by both parties, according to a modified appeals procedure established by the Department and the Office of Administrative Hearings. In any proceeding, the appealing party must demonstrate by a preponderance of the evidence that the Department's determination is incorrect or not according to law.

A. To appeal a payment rate or payment determination or a determination made from base year information, the hospital must file a written appeal request to the Department within 60 days of the date the payment rate determination was mailed to the hospital. The appeal request shall specify:

(1) The disputed items.

(2) The authority in federal or state statute or rule upon which the hospital relies for each disputed item.

(3) The name and address of the person to contact regarding the appeal.

B. To appeal a payment rate or payment change that results from a difference in case mix between the base year and the rate year, the procedures and requirements listed above apply. However, the appeal must be filed with the Department or postmarked within 120 days after the end of the rate year. A case mix appeal must apply to the cost of services to all Medical Assistance patients who received inpatient services from the hospital for which the hospital received Medical Assistance payment, excluding Medicare crossovers. The appeal is effective for the entire rate year. A case mix appeal excludes Medical Assistance admissions that have a relative value of zero for its DRG.

A. The adjustment to each hospital is calculated as the difference between payments made under this State plan and what was paid under each State plan in effect from July 1, 1992 to October 24, 1993, excluding the indigent care payment, with the following adjustments.

(1) Rates under this State plan are deflated 5.4 percent to remove the 1993 HCI. Rates are not deflated when the admissions under adjustment occurred in 1993.

(2) The core hospital increase is included when the admissions under adjustment occurred under a State plan that included it (July 1, 1993).

(3) The small rural payment adjustment is included when the admissions under adjustment occurred under a State plan that included it (October 1, 1992).

(4) The hospital payment adjustment is included when the admissions under adjustment occurred under a State plan that included it (July 1, 1993).

(5) The DPA is calculated using base year data under this State plan and the formulas under the State plan in effect for the admissions under adjustment (changed October 1, 1992).

(6) The cash flow payment adjustment under all State plans from July 1, 1992 to October 24, 1993 is deducted from the payment for admissions under adjustment.

B. Aggregate amounts owed to the hospital under item A are reduced by twenty percent. Payments for the cash flow payment adjustment are subtracted. The net difference is divided by 1.5 times the number of admissions under adjustment after mother and baby admissions are separated to derive a per admission adjustment. A hospital with an aggregate amount owed to the Department that exceeds one million dollars and has a payment reduction due to rebasing that exceeds twenty percent will have the net difference divided by 3.0 times the number of admissions under adjustment.

C. The rebasing adjustment will be added to or subtracted from each payment for admissions excluding Medicare crossovers, occurring on or after October 25, 1993 until the aggregate amount due to or owed by a hospital is fully paid.

D. The rebasing adjustment will occur over two periods.

(1) The first adjustment for admissions occurring from July 1, 1992 to December 31, 1992 and paid by August 1, 1993 begins with admissions occurring on or after October 25, 1993.

(2) The second adjustment for admissions occurring from January 1, 1993 to October 24, 1993 and paid by February 1, 1994 begins the later of February 1, 1994 or after the first adjustment is fully paid.

15.06 Out of state negotiation. Out-of-area payments will be established based on a negotiated rate if a hospital shows that the automatic payment of the out-of-area hospital rate per admission is below the hospital's allowable cost of the services. A rate is not negotiated until the claim is received and allowable costs are determined. Payments, including third party liability, may not exceed the charges on a claim specific basis for inpatient hospital services that are covered by Medical Assistance.

15.07 Psychiatric services contracts. The Commissioner has determined that there is a need for access to additional inpatient hospital psychiatric beds for persons with serious and persistent mental illness who have been civilly committed or voluntarily hospitalized and can be treated and discharged within 45 days. In response, contracts with non-state operated hospitals to provide inpatient hospital psychiatric services to patients who will be dually committed to the non-state operated hospital and the State-operated regional treatment center, or who have agreed to hospitalization, have been established. Payment rates for these inpatient psychiatric services are negotiated and established in the contracts executed under an open bidding process between the Commissioner and the hospitals.